Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Allergy Testing	$5 copay.	$5 copay Primary Care Physician; $10 copay Specialist.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	80% after deductible.
Deductible	Copay where applicable.	No Annual Deductible.	**High Option -** In network: none; Out-of-network: $300 individual; $600 family. **Standard Option** - Same as High Option	**High Option -** In network: none; Out-of-network: $250 individual; $500 family. **Standard Option** - Same as High Option	$200 individual deductible; $400 family deductible.
Diagnostic/Lab/X-Ray	Covered in full.	Covered in full. No Copayment.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	100% up to $500 for services related to an illness in a calendar year (there is a separate limit of $500 for services related to an accident in a calendar year); 80% for services in excess of the $500 limit for either an illness or an accident in a calendar year.
Dr. Office Visits	$5 copay.	$5 copay Primary Care Physician; $10 copay Specialist.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $15 copay; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $15 copay; Out-of-network: same as High Option.	80% after deductible.
Emergency Room	$50 copay – waived if admitted to hospital.	$25 copay (plan definition of emergency must be met) – waived if admitted to hospital; $15 copay for Urgent Care Centers.	**High Option -** In network: $25 copay waived if admitted to hospital; Out-of-network: 80% after deductible. **Standard Option** – In network: $35 copay waived if admitted to hospital; Out-of-network: same as High Option.	**High Option -** In network: $50 copay, waived if admitted; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	Covered in full if life-threatening or accidental injury; 80% after deductible for illness.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Hearing Aids	Under age 18. Up to $1,400 per hearing aid for each hearing impaired ear every 36 months.	Under age 19 up to $1,400 per hearing aid for each hearing impaired ear every 36 months.	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.
Hearing Screening	$5 copay for hearing exam (hearing aids are excluded).	$5 copay Primary Care Physician; $10 copay Specialist.	**High Option -** In network: childhood hearing screening covered in full; Out-of-network: childhood hearing screening, 80% not subject to deductible. **Standard Option** – Same as High Option.	**High Option -** In network: childhood hearing screening covered in full; Out-of-network: childhood hearing screening, 80% not subject to deductible. **Standard Option** – Same as High Option.	Not covered.
Home Health Care Services	Covered in full if medically necessary.	Covered in full. No copayment; 60 visit maximum for skilled care services per calendar year.	**High Option -** In network: covered in full (90 visits max/calendar year); Out-of-network: 80% after deductible (90 visits max/calendar year). **Standard Option** – Same as High Option.	**High Option -** In network: covered in full (40 visits per calendar year); Out-of-network: 80% after deductible (40 visits per calendar year). **Standard Option** – Same as High Option.	Covered in full; 40 visits maximum/calendar year.
Hospice	Covered in full.	Covered in full. (See coverage booklet for eligibility information.)	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	Covered in full; $5,000 maximum.
Hospital	Covered in full.	Covered in full.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option –** In network: covered in full after $150 copay per admission; Out-of-network: same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – In network: covered in full after $150 copay per admission; Out-of-network: same as High Option.	Covered in full; 180 day maximum per confinement.
Immunizations	$5 copay. Included in well child care visits up to age 5 at no charge.	$5 copay Primary Care Physician	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full when billed with office visit; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	Maximum $15 per immunization ($45 per calendar year maximum per member); balance paid at 80% after deductible.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
In vitro Fertilization	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.
Mammography - Preventive Screening Schedule	Schedule consistent with the current recommendations of the American College of Physicians.	Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.	**High Option –** Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year. **Standard Option** - Same as High Option	**High Option –** Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year. **Standard Option** - Same as High Option	Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.
Maternity	Covered in full once pregnancy is diagnosed.	No copayment applies after the first visit.	**High Option -** In network: first visit 100% after $10 copay; other visits 100%; Out-of-network: 80% after deductible. **Standard Option –** In network: first visit 100% after $30 copay; other visits 100%; Out-of-network: same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – In network: first visit 100% after $30 copay; other visits 100%; Out-of-network - Same as High Option.	100% up to amount allowed by plan.
Maximum Lifetime Benefit	Unlimited Maximum.	Unlimited Maximum.	**High Option -** Unlimited Maximum. **Standard Option -** Same as High Option	**High Option -** Unlimited Maximum. **Standard Option -** Same as High Option	Individual: Unlimited Maximum for major medical services.
Out-of-Pocket Annual Maximum	N/A	$1,100 per individual up to a cap of $3,600 for a family	**High Option -** Per Individual: $1,000 plus the annual deductible. **Standard Option** - Same as High Option	**High Option -** In network: Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible; Out-of-network: Individual: $2,000 plus the annual deductible; Family: $4,000 plus the annual deductible. **Standard Option** - Same as High Option	Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Physical	$5 copay.	$5 copay Primary Care Physician;	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible (limit 1/calendar year). **Standard Option** - In network: $15 copay Primary Care Physician; $30 copay Specialist; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible (limit 1/calendar year). **Standard Option** - In network: $15 copay Primary Care Physician; $30 copay Specialist; Out-of-network: same as High Option.	Up to $75/exam every 2 years - employee and spouse only; balance is paid at 80% after deductible.
Prescriptions	**Kaiser Rx Plan (included with Kaiser HMO medical plan):** $5 at on-site pharmacies and for mail order; $15 at participating community pharmacies.	**No Rx Plan included; diabetic supplies covered under a pharmacy rider.**	**High and Standard Option – No Rx Plan included; diabetic supplies covered under a pharmacy rider.**	**High and Standard Option – No Rx Plan included; diabetic supplies covered under a pharmacy rider.**	80% after deductible. Prescription discount program included with mail order feature.
Rehabilitation Services	Inpatient: Covered in full (Unlimited). Outpatient: $5 copay; outpatient services for physical therapy are limited to up to 30 visits; occupational and speech therapy per injury, incident or condition are covered for a period not to exceed 90 days.	$10 copay/visit. 60 combined visits per year (short-term non-chronic conditions only).	**High Option -** In network: 100%; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	80% after deductible.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Skilled Nursing Facility	Covered in full; 100 days maximum.	Covered in full 60 days per calendar year maximum.	**High Option -** In network: covered in full (100 days max/calendar year); Out-of-network: 80% after deductible (100 days max/calendar year). **Standard Option -** Same as High Option	**High Option -** In network: covered in full (60 days max/calendar year); **Standard Option** – Same as High Option.	$30/day, up to 360 days per calendar year; $10,800 calendar year maximum.
Specialists	$5 copay.	$10 copay.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $30 copay; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% after deductible. **Standard Option -** In network: $30 copay; Out-of-network: same as High Option.	80% after deductible.
Substance Abuse/Mental Health	Inpatient: Covered in full; Outpatient/ individual visits: $20 copay per visit; group visits: $10 copay per visit.	Inpatient: Covered in full; Outpatient visits: 1-5 20% copay; 6-30 35% copay; 31+ 50% copay. $10 copay per visit for Medication management office visit. $25 copay up to 60 days per calendar year for Partial Hospitalization	**High Option -** In network: Inpatient- covered in full; Outpatient- visits 1-5 100%; 70% thereafter; Out-of-network: Inpatient- 80% after deductible; Outpatient- 80% first 5 visits; 65% next 25 visits; 50% each thereafter (all outpatient visits subject to deductible). **Standard Option** – Same as High Option.	**High Option -** In network: Inpatient – covered in full; Outpatient- visits 1-5 100%; visits 6-30 80%; 31+ 50%; Out-of-network: Inpatient- 80% after deductible; Outpatient- visits 1-5 80%; visits 6-30 65%; visits 31+ 50% (all outpatient visits subject to deductible). **Standard Option** – Same as High Option.	Inpatient- 100% to 180 days (lifetime maximum does not apply); Outpatient- 80% after deductible.
Surgery	Covered in full.	Inpatient: covered in full; Outpatient: $25 copay.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	**High Option -** In network: covered in full; Out-of-network: 80% after deductible. **Standard Option** – Same as High Option.	100% up to amount allowed by plan.

Health Plan (Assumes Primary Coverage)	Kaiser Permanente	United Healthcare	Carefirst Blue Cross Blue Shield		
			POS High and Standard Option Plans In Service Area	POS High and Standard Option Plans Out of Area	Indemnity Plan (closed to new members)
Vision (Routine)	$5 copay for exams; 25% discount on lenses/frames at Kaiser centers; 15% discount off the cost of contact lenses.	$25 copay/exam; 15%-20% discount through participating optical centers.	**High Option -** In network: refraction not covered; (pediatric visual screening - covered in full under well child care). Out-of-network: refraction not covered (pediatric visual screening - 80% not subject to deductible under well child care). **Standard Option** - Same as High Option	**High Option -** In network: refraction not covered (pediatric visual screening – covered in full under well child care); Out-of-network: refraction not covered (pediatric visual screening – 80% not subject to deductible under well childcare). **Standard Option** - Same as High Option	None.
Well Child Care	Well baby/well child covered in full up to age 5.	$5 copay Primary Care Physician	**High Option -** In network: $10 copay; Out-of-network: 80% not subject to deductible (up to age 18). **Standard Option** - In network: $15 copay; Out-of-network: same as High Option.	**High Option -** In network: $10 copay; Out-of-network: 80% not subject to deductible (up to age 18). **Standard Option** - In network: $15 copay; Out-of-network: same as High Option.	100% for child wellness (including related lab tests and X-rays) up to age 18.

Note: This comparison is to be used as a guide only and not as the benefits offered. Consult the individual plan booklets for complete information. (Rev. 9/10)